STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING _____	C 07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00093628 and IN00094072. This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on July 7, 2011 to the Recertification and State Licensure Survey completed on April 29, 2011. This visit was in conjunction with a PSR to the PSR completed on July 7, 2011 to the Investigation of Complaint IN00090093 and IN00090287 completed on May 13, 2011. This visit was in conjunction with a PSR to the PSR completed on July 7, 2011 to the Investigation of Complaint IN00090903 completed on June 7, 2011. Complaint IN00093628 Substantiated - No deficiencies related to the allegation(s) are cited. Complaint IN00094072 - Substantiated - No deficiencies related to the allegation(s) are cited. Survey date(s): July 27, 28, 2011 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Donna Groan RN, TC Dorothy Navetta RN Census bed type: SNF: 8 SNF/NF: 59	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING _____ B. WING _____	C 07/28/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	**517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN 47129**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Total: 67 Census payor type: Medicare: 10 Medicaid: 48 Other: 9 Total: 67 Sample: 3 Clark Rehabilitation and Skilled Nursing Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to Complaints IN00093628 and IN00094072. Quality review completed 7/29/11 Cathy Emswiller RN	F 000		